## SENATE BILL No. 294

### DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15.

**Synopsis:** Disproportionate share hospital providers. Requires disproportionate share payments to be distributed in a uniform and equitable manner. Makes changes to the distribution formulas for disproportionate share payments.

Effective: July 1, 2010.

## Merritt

January 11, 2010, read first time and referred to Committee on Appropriations.



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#### Second Regular Session 116th General Assembly (2010)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in this style type, and deletions will appear in this style type.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2009 Regular and Special Sessions of the General Assembly.

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## SENATE BILL No. 294

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

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Be it enacted by the General Assembly of the State of Indiana:

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SECTION 1. IC 12-15-15-1.1, AS AMENDED BY P.L.218-2	2007,
SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECT	ΓIVE
JULY 1, 2010]: Sec. 1.1. (a) This section applies to a hospital th	at is:

- (1) licensed under IC 16-21; and
- (2) established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.
- (b) For a state fiscal year ending after June 30, 2003, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated as follows:

STEP ONE: The office shall identify the aggregate inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by hospitals established and operated under IC 16-22-2, IC 16-22-8, or IC 16-23.

STEP TWO: For the aggregate inpatient hospital services identified under STEP ONE, the office shall calculate the aggregate payments made under this article and under the state



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1	Medicaid plan to hospitals established and operated under	
2	IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under	
3	IC 12-15-16, IC 12-15-17, and IC 12-15-19.	
4	STEP THREE: The office shall calculate a reasonable estimate of	
5	the amount that would have been paid in the aggregate by the	
6	office for the inpatient hospital services described in STEP ONE	
7	under Medicare payment principles.	
8	STEP FOUR: Subtract the amount calculated under STEP TWO	
9	from the amount calculated under STEP THREE.	
10	STEP FIVE: Subject to subsection (g), from the amount	
11	calculated under STEP FOUR, allocate to a hospital established	
12	and operated under IC 16-22-8 an amount not to exceed one	
13	hundred percent (100%) of the difference between:	
14	(A) the total cost for the hospital's provision of inpatient	
15	services covered under this article for the hospital's fiscal year	
16	ending during the state fiscal year; and	
17	(B) the total payment to the hospital for its provision of	
18	inpatient services covered under this article for the hospital's	
19	fiscal year ending during the state fiscal year, excluding	
20	payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.	
21	STEP SIX: Subtract the amount calculated under STEP FIVE	
22	from the amount calculated under STEP FOUR.	
23	STEP SEVEN: Distribute an amount equal to the amount	
24	calculated under STEP SIX to the eligible hospitals established	
25	and operated under IC 16-22-2 or IC 16-23 described in	
26	subsection (c) in an amount not to exceed each hospital's	
27	Medicaid shortfall as defined in subsection (f).	
28	(c) Subject to subsection (e), reimbursement for a state fiscal year	
29	under this section consists of payments made after the close of each	
30	state fiscal year. A hospital is not eligible for a payment described in	
31	this subsection unless an intergovernmental transfer or certification of	
32	expenditures is made under subsection (d).	
33	(d) Subject to subsection (e):	
34	(1) an intergovernmental transfer may be made by or on behalf of	
35	the hospital; or	
36	(2) a certification of expenditures as eligible for federal financial	
37	participation may be made;	
38	after the close of each state fiscal year. An intergovernmental transfer	
39	under this subsection must be made to the Medicaid indigent care trust	
40	fund in an amount equal to a percentage, as determined by the office,	
41	of the amount to be distributed to the hospital under this section. The	
42	office shall use the intergovernmental transfer to fund payments made	



under this section.

(e) A hospital that makes a certification of expenditures or makes or has an intergovernmental transfer made on the hospital's behalf under this section may appeal under IC 4-21.5 the amount determined by the office to be paid the hospital under subsection (b). The periods described in subsections (c) and (d) for the hospital or another entity to make an intergovernmental transfer or certification of expenditures are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5. The distribution to other hospitals under subsection (b) may not be delayed due to an administrative appeal or judicial review instituted by a hospital under this subsection. If necessary, the office may make a partial distribution to the other eligible hospitals under subsection (b) pending the completion of a hospital's administrative appeal or judicial review, at which time the remaining portion of the payments due to the eligible hospitals shall be made. A partial distribution may be based upon estimates and trends calculated by the office.

- (f) For purposes of this section:
  - (1) the Medicaid shortfall of a hospital established and operated under IC 16-22-2 or IC 16-23 is calculated as follows:

STEP ONE: The office shall identify the inpatient hospital services, reimbursable under this article and under the state Medicaid plan, that were provided during the state fiscal year by the hospital.

STEP TWO: For the inpatient hospital services identified under STEP ONE, the office shall calculate the payments made under this article and under the state Medicaid plan to the hospital, excluding payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.

STEP THREE: The office shall calculate a reasonable estimate of the amount that would have been paid by the office for the inpatient hospital services described in STEP ONE under Medicare payment principles; and

- (2) a hospital's Medicaid shortfall is equal to the amount by which the amount calculated in STEP THREE of subdivision (1) is greater than the amount calculated in STEP TWO of subdivision (1).
- (g) The actual distribution of the amount calculated under STEP FIVE of subsection (b) to a hospital established and operated under IC 16-22-8 shall be made under the terms and conditions provided for the hospital in the state plan for medical assistance. Payment to a hospital under STEP FIVE of subsection (b) is not a condition











1	precedent to the tender of payments to hospitals under STEP SEVEN
2	of subsection (b).
3	SECTION 2. IC 12-15-15-1.3, AS AMENDED BY P.L.218-2007,
4	SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
5	JULY 1, 2010]: Sec. 1.3. (a) This section applies to a hospital that is:
6	(1) licensed under IC 16-21; and
7	(2) established and operated under IC 16-22-2, IC 16-22-8, or
8	IC 16-23.
9	(b) For a state fiscal year ending after June 30, 2003, in addition to
10	reimbursement received under section 1 of this chapter, a hospital is
11	entitled to reimbursement in an amount calculated as follows:
12	STEP ONE: The office shall identify the aggregate outpatient
13	hospital services, reimbursable under this article and under the
14	state Medicaid plan, that were provided during the state fiscal
15	year by hospitals established and operated under IC 16-22-2,
16	IC 16-22-8, or IC 16-23.
17	STEP TWO: For the aggregate outpatient hospital services
18	identified under STEP ONE, the office shall calculate the
19	aggregate payments made under this article and under the state
20	Medicaid plan to hospitals established and operated under
21	IC 16-22-2, IC 16-22-8, or IC 16-23, excluding payments under
22	IC 12-15-16, IC 12-15-17, and IC 12-15-19.
23	STEP THREE: The office shall calculate a reasonable estimate of
24	the amount that would have been paid in the aggregate by the
25	office under Medicare payment principles for the outpatient
26	hospital services described in STEP ONE.
27	STEP FOUR: Subtract the amount calculated under STEP TWO
28	from the amount calculated under STEP THREE.
29	STEP FIVE: Subject to subsection (g), (f), from the amount
30	calculated under STEP FOUR, allocate to a hospital established
31	and operated under IC 16-22-8 an amount not to exceed one
32	hundred percent (100%) of the difference between:
33	(A) the total cost for the hospital's provision of outpatient
34	services covered under this article for the hospital's fiscal year
35	ending during the state fiscal year; and
36	(B) the total payment to the hospital for its provision of
37	outpatient services covered under this article for the hospital's
38	fiscal year ending during the state fiscal year, excluding
39	payments under IC 12-15-16, IC 12-15-17, and IC 12-15-19.
40	STEP SIX: Subtract the amount calculated under STEP FIVE
41	from the amount calculated under STEP FOUR.
12	STEP SEVEN: Distribute an amount equal to the amount



1	calculated under STEP SIX to the eligible hospitals established
2	and operated under IC 16-22-2 or IC 16-23 described in
3	subsection (c) in an amount not to exceed each hospital's
4	Medicaid shortfall as defined in subsection (f). (e).
5	(c) A hospital is not eligible for a payment described in this section
6	unless:
7	(1) an intergovernmental transfer is made by the hospital or on
8	behalf of the hospital; or
9	(2) the hospital or another entity certifies the hospital's
.0	expenditures as eligible for federal financial participation.
1	(d) (c) Subject to subsection (e): (d):
2	(1) an intergovernmental transfer may be made by or on behalf of
3	the hospital; or
4	(2) a certification of expenditures as eligible for federal financial
5	participation may be made;
6	after the close of each state fiscal year. An intergovernmental transfer
7	under this subsection must be made to the Medicaid indigent care trust
. 8	fund in an amount equal to a percentage, as determined by the office,
9	of the amount to be distributed to the hospital under subsection (b). The
20	office shall use the intergovernmental transfer to fund payments made
21	under this section.
22	(e) (d) A hospital that makes a certification of expenditures or
23	makes or has an intergovernmental transfer made on the hospital's
24	behalf under this section may appeal under IC 4-21.5 the amount
2.5	determined by the office to be paid by the hospital under subsection
26	(b). The periods period described in subsections (c) and subsection (d)
27	for the hospital or other entity to make an intergovernmental transfer
28	or certification of expenditures are is tolled pending the administrative
29	appeal and any judicial review initiated by the hospital under IC 4-21.5.
0	The distribution to other hospitals under subsection (b) may not be
1	delayed due to an administrative appeal or judicial review instituted by
32	a hospital under this subsection. If necessary, the office may make a
33	partial distribution to the other eligible hospitals under subsection (b)
34	pending the completion of a hospital's administrative appeal or judicial
35	review, at which time the remaining portion of the payments due to the
66	eligible hospitals must be made. A partial distribution may be
37	calculated by the office based upon estimates and trends.
8	(f) (e) For purposes of this section:
19	(1) the Medicaid shortfall of a hospital established and operated
10	under IC 16-22-2 or IC 16-23 is calculated as follows:
1	STEP ONE: The office shall identify the outpatient hospital
12	services, reimbursable under this article and under the state



1	Medicaid plan, that were provided during the state fiscal year	
2	by the hospital.	
3	STEP TWO: For the outpatient hospital services identified	
4	under STEP ONE, the office shall calculate the payments	
5	made under this article and under the state Medicaid plan to	
6	the hospital, excluding payments under IC 12-15-16,	
7	IC 12-15-17, and IC 12-15-19.	
8	STEP THREE: The office shall calculate a reasonable estimate	
9	of the amount that would have been paid by the office for the	
10	outpatient hospital services described in STEP ONE under	
11	Medicare payment principles; and	
12	(2) a hospital's Medicaid shortfall is equal to the amount by which	
13	the amount calculated in STEP THREE of subdivision (1) is	
14	greater than the amount calculated in STEP TWO of subdivision	
15	(1).	
16	(g) (f) The actual distribution of the amount calculated under STEP	
17	FIVE of subsection (b) to a hospital established and operated under	
18	IC 16-22-8 shall be made under the terms and conditions provided for	
19	the hospital in the state plan for medical assistance. Payment to a	
20	hospital under STEP FIVE of subsection (b) is not a condition	
21	precedent to the tender of payments to hospitals under STEP SEVEN	
22	of subsection (b).	
23	SECTION 3. IC 12-15-15-1.5, AS AMENDED BY P.L.3-2008,	
24	SECTION 92, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	
25	JULY 1, 2010]: Sec. 1.5. (a) This section applies to a hospital that:	
26	(1) is licensed under IC 16-21;	
27	(2) is not a unit of state or local government; and	
28	(3) is not owned or operated by a unit of state or local	
29	government.	
30	(b) For a state fiscal year ending after June 30, 2003, and before July	
31	1, 2007, in addition to reimbursement received under section 1 of this	
32	chapter, a hospital eligible under this section is entitled to	
33	reimbursement in an amount calculated as follows:	
34	STEP ONE: The office shall identify the total inpatient hospital	
35	services and the total outpatient hospital services, reimbursable	
36	under this article and under the state Medicaid plan, that were	
37	provided during the state fiscal year by the hospitals described in	
38	subsection (a).	
39	STEP TWO: For the total inpatient hospital services and the total	
40	outpatient hospital services identified under STEP ONE, the	
41	office shall calculate the aggregate payments made under this	
42	article and under the state Medicaid plan to hospitals described in	



1	subsection (a), excluding payments under IC 12-15-16,
2	IC 12-15-17, and IC 12-15-19.
3	STEP THREE: The office shall calculate a reasonable estimate of
4	the amount that would have been paid in the aggregate by the
5	office for the inpatient hospital services and the outpatient
6	hospital services identified in STEP ONE under Medicare
7	payment principles.
8	STEP FOUR: Subtract the amount calculated under STEP TWO
9	from the amount calculated under STEP THREE.
10	STEP FIVE: Distribute an amount equal to the amount calculated
11	under STEP FOUR to the eligible hospitals described in
12	subsection (a) as follows:
13	(A) Subject to the availability of funds under
14	IC 12-15-20-2(8)(D) to serve as the nonfederal share of such
15	payment, the first ten million dollars (\$10,000,000) of the
16	amount calculated under STEP FOUR for a state fiscal year
17	shall be paid to a hospital described in subsection (a) that has
18	more than sixty thousand (60,000) Medicaid inpatient days.
19	(B) Following the payment to the hospital under clause (A)
20	and subject to the availability of funds under
21	IC 12-15-20-2(8)(D) to serve as the nonfederal share of such
22	payments, the remaining amount calculated under STEP
23	FOUR for a state fiscal year shall be paid to all hospitals
24	described in subsection (a). The payments shall be made on a
25	pro rata basis based on the hospitals' Medicaid inpatient days
26	or other payment methodology approved by the Centers for
27	Medicare and Medicaid Services. For purposes of this clause,
28	a hospital's Medicaid inpatient days are the hospital's in-state
29	and paid Medicaid fee for service and managed care days for
30	the state fiscal year for which services are identified under
31	STEP ONE, as determined by the office.
32	(C) Subject to IC 12-15-20.7, in the event the entirety of the
33	amount calculated under STEP FOUR is not distributed
34	following the payments made under clauses (A) and (B), the
35	remaining amount may be paid to hospitals: described in
36	subsection (a) that are eligible under this clause. A hospital is
37	eligible for a payment under this clause only if the nonfederal
38	share of the hospital's payment is provided by or on behalf of
39	the hospital. The remaining amount shall be paid to those
40	eligible hospitals:
41	(i) on a pro rata basis in relation to all hospitals eligible
42	under this clause based on the hospitals' Medicaid inpatient



1	days; or
2	(ii) other payment methodology determined by the office
3	and approved by the Centers for Medicare and Medicaid
4	Services.
5	(c) As used in this subsection, "Medicaid supplemental payments"
6	means Medicaid payments for hospitals that are in addition to Medicaid
7	fee-for-service payments, Medicaid risk-based managed care payments,
8	and Medicaid disproportionate share payments, and that are included
9	in the Medicaid state plan, including Medicaid safety-net payments,
0	and payments made under this section and sections 1.1, 1.3, 9, and 9.5
1	of this chapter. For a state fiscal year ending after June 30, 2007, in
2	addition to the reimbursement received under section 1 of this chapter,
3	a hospital eligible under this section is entitled to reimbursement in an
4	amount calculated as follows:
5	STEP ONE: The office shall identify the total inpatient hospital
6	services and the total outpatient hospital services reimbursable
7	under this article and under the state Medicaid plan that were
. 8	provided during the state fiscal year for all hospitals described in
9	subsection (a).
20	STEP TWO: For the total inpatient hospital services and the total
21	outpatient hospital services identified in STEP ONE, the office
22	shall calculate the total payments made under this article and
23	under the state Medicaid plan to all hospitals described in
24	subsection (a). A calculation under this STEP excludes a payment
2.5	made under the following:
26	(A) IC 12-15-16.
27	(B) IC 12-15-17.
28	(C) IC 12-15-19.
29	STEP THREE: The office shall calculate, under Medicare
0	payment principles, a reasonable estimate of the total amount that
1	would have been paid by the office for the inpatient hospital
32	services and the outpatient hospital services identified in STEP
3	ONE.
4	STEP FOUR: Subtract the amount calculated under STEP TWO
55	from the amount calculated under STEP THREE.
66	STEP FIVE: Distribute an amount equal to the amount calculated
57	under STEP FOUR to the eligible hospitals described in
8	subsection (a) as follows:
9	(A) As used in this clause, "Medicaid inpatient days" are the
10	hospital's in-state paid Medicaid fee for service and risk-based
1	managed care days for the state fiscal year for which services
.2	are identified under STEP ONE, as determined by the office



1	Subject to the availability of funds transferred to the Medicaid
2	indigent care trust fund under STEP FOUR of
3	IC 12-16-7.5-4.5(c) and remaining in the Medicaid indigent
4	care trust fund under IC 12-15-20-2(8)(G) to serve as the
5	nonfederal share of the payments, the amount calculated under
6	STEP FOUR for a state fiscal year shall be paid to all hospitals
7	described in subsection (a). The payments shall be made on a
8	pro rata basis, based on the hospitals' Medicaid inpatient days
9	or in accordance with another payment methodology
10	determined by the office and approved by the Centers for
11	Medicare and Medicaid Services.
12	(B) Subject to IC 12-15-20.7, if the entire amount calculated
13	under STEP FOUR is not distributed following the payments
14	made under clause (A), the remaining amount shall be paid as
15	described in clauses clause (C) and (D) to a hospital that is
16	described in subsection (a) and that is described as eligible
17	under this clause. A hospital is eligible for a payment under
18	clause (C) only if the hospital
19	(i) has less than sixty thousand (60,000) Medicaid inpatient
20	days annually.
21	(ii) was eligible for Medicaid disproportionate share hospital
22	payments in the state fiscal year ending June 30, 1998, or
23	the hospital met the office's Medicaid disproportionate share
24	payment criteria based upon state fiscal year 1998 data and
25	received a Medicaid disproportionate share payment for the
26	state fiscal year ending June 30, 2001; and
27	(iii) received a Medicaid disproportionate share payment
28	under IC 12-15-19-2.1 for state fiscal years 2001, 2002,
29	2003, and 2004.
30	The payment amount under clause (C) for an eligible hospital
31	is subject to the availability of the nonfederal share of the
32	hospital's payment being provided by the hospital or on behalf
33	of the hospital.
34	(C) For state fiscal years ending after June 30, 2007, but
35	before July 1, 2009, payments to eligible hospitals described
36	in clause (B) shall be made as follows:
37	(i) The payment to an eligible hospital that merged two (2)
38	hospitals under a single Medicaid provider number effective
39	January 1, 2004, shall equal one hundred percent (100%) of
40	the hospital's hospital-specific limit for the state fiscal year
41	ending June 30, 2005, when the payment is combined with
42	any Medicaid disproportionate share payment made under
	any medicale disproportionate share payment made under



1	IC 12-15-19-2.1, Medicaid, and other Medicaid
2	supplemental payments, paid or to be paid to the hospital for
3	a state fiscal year.
4	(ii) The payment to an eligible hospital described in clause
5	(B) other than a hospital described in item (i) shall equal one
6	hundred percent (100%) of the hospital's hospital specific
7	limit for the state fiscal year ending June 30, 2004, when the
8	payment is combined with any Medicaid disproportionate
9	share payment made under IC 12-15-19-2.1, Medicaid, and
10	other Medicaid supplemental payments, paid or to be paid
11	to the hospital for a state fiscal year.
12	(D) For state fiscal years beginning after June 30, 2009,
13	payments to an eligible hospital described in clause (B) shall
14	be made in a uniform and equitable manner determined by
15	the office.
16	(E) (D) Subject to IC 12-15-20.7, if the entire amount
17	calculated under STEP FOUR is not distributed following the
18	payments made under clause clauses (A) and clauses (C), or
19	(D), the remaining amount may be paid as described in clause
20	(F) (E) to a hospital described in subsection (a) that is
21	described as eligible under this clause. A hospital is eligible
22	for a payment for a state fiscal year under clause (F) (E) if the
23	hospital:
24	(i) is eligible to receive Medicaid disproportionate share
25	payments for the state fiscal year for which the Medicaid
26	disproportionate share payment is attributable under
27	IC 12-15-19-2.1, for a state fiscal year ending after June 30,
28	2007; and
29	(ii) does not receive a payment under clauses clause (C) or
30	(D) for the state fiscal year.
31	A payment to a hospital under this clause is subject to the
32	availability of nonfederal matching funds.
33	(F) (E) Payments to eligible hospitals described in clause (E)
34	(D) shall be made:
35	(i) to best use federal matching funds available for hospitals
36	that are eligible for Medicaid disproportionate share
37	payments under IC 12-15-19-2.1; and
38	(ii) by using a methodology that allocates available funding
39	under this clause, Medicaid supplemental payments, and
40	payments under IC 12-15-19-2.1, in a manner in which all
41	hospitals eligible under clause (E) (D) receive payments in
42	a manner that takes into account the situation of eligible



1	hospitals that have historically qualified for Medicaid
2	disproportionate share payments and ensures that payments
3	for eligible hospitals are equitable.
4	(G) (F) If the Centers for Medicare and Medicaid Services
5	does not approve the payment methodologies in clauses (A)
6	through (F), (E), the office may implement alternative
7	payment methodologies that are eligible for federal financial
8	participation to implement a program consistent with the
9	payments for hospitals described in clauses (A) through <del>(F).</del>
.0	(E).
.1	(d) A hospital described in subsection (a) may appeal under
.2	IC 4-21.5 the amount determined by the office to be paid to the hospital
.3	under STEP FIVE of subsections (b) or (c). The distribution to other
4	hospitals under STEP FIVE of subsection (b) or (c) may not be delayed
.5	due to an administrative appeal or judicial review instituted by a
.6	hospital under this subsection. If necessary, the office may make a
.7	partial distribution to the other eligible hospitals under STEP FIVE of
. 8	subsection (b) or (c) pending the completion of a hospital's
9	administrative appeal or judicial review, at which time the remaining
20	portion of the payments due to the eligible hospitals shall be made. A
2.1	partial distribution may be based on estimates and trends calculated by
22	the office.
23	SECTION 4. IC 12-15-16-1, AS AMENDED BY P.L.123-2008,
24	SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
25	JULY 1, 2010]: Sec. 1. (a) A provider that is an acute care hospital
26	licensed under IC 16-21, a state mental health institution under
27	IC 12-24-1-3, or a private psychiatric institution licensed under
28	IC 12-25 is a disproportionate share provider if the provider meets
29	either of the following conditions:
0	(1) The provider's Medicaid inpatient utilization rate is at least
31	one (1) standard deviation above the mean Medicaid inpatient
32	utilization rate for providers receiving Medicaid payments in
33	Indiana. However, the Medicaid inpatient utilization rate of
34	providers whose low income utilization rate exceeds twenty-five
55	percent (25%) must be excluded in calculating the statewide
66	mean Medicaid inpatient utilization rate.
37	(2) The provider's low income utilization rate exceeds twenty-five
8	percent (25%).
19	(b) An acute care hospital licensed under IC 16-21 is a municipal
10	disproportionate share provider if the hospital:
1	(1) has a Medicaid utilization rate greater than one percent (1%);
12	and



1	(2) is established and operated under IC 16-22-2 or IC 16-23.
2	(c) A community mental health center:
3	(1) that is identified in IC 12-29-2-1;
4	(2) for which a county provides funds under:
5	(A) IC 12-29-1-7(b) before January 1, 2004; or
6	(B) IC 12-29-2-20(d) after December 31, 2003;
7	or from other county sources; and
8	(3) that provides inpatient services to Medicaid patients;
9	is a community mental health center disproportionate share provider if
10	the community mental health center's Medicaid inpatient utilization
11	rate is greater than one percent $(1\%)$ .
12	(d) A disproportionate share provider under IC 12-15-17 must have
13	at least two (2) obstetricians who have staff privileges and who have
14	agreed to provide obstetric services under the Medicaid program. For
15	a hospital located in a rural area (as defined in Section 1886 of the
16	Social Security Act), an obstetrician includes a physician with staff
17	privileges at the hospital who has agreed to perform nonemergency
18	obstetric procedures. However, this obstetric service requirement does
19	not apply to a provider whose inpatients are predominantly individuals
20	less than eighteen (18) years of age or that did not offer nonemergency
21	obstetric services as of December 21, 1987.
22	(e) The determination of a provider's status as a disproportionate
23	share provider under this section shall be based on utilization and
24	revenue data from the most recent year for which an audited cost report
25	from the provider is on file with the office.
26	(f) The office shall make disproportionate share payments to a
27	hospital eligible under this section in a manner that is uniform and
28	equitable to all hospitals, regardless of the year in which the
29	hospital became eligible for a payment. The office shall apply to the
30	United States Department of Health and Human Services to amend
31	the state Medicaid plan to comply with this subsection.
32	SECTION 5. IC 12-15-19-2.1, AS AMENDED BY P.L.218-2007,
33	SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
34	JULY 1, 2010]: Sec. 2.1. (a) For each state fiscal year ending on or
35	after June 30, 2000, the office shall develop a disproportionate share
36	payment methodology that ensures that each hospital qualifying for
37	disproportionate share payments under IC 12-15-16-1(a) timely
38	receives total disproportionate share payments that do not exceed the
39	hospital's hospital specific limit provided under 42 U.S.C. 1396r-4(g).
40	The payment methodology as developed by the office must:
41	(1) maximize disproportionate share hospital payments to

qualifying hospitals to the extent practicable; and



1	(2) take into account the situation of those qualifying hospitals	
2	that have historically qualified for Medicaid disproportionate	
3	share payments; and	
4	(3) (2) ensure that payments for qualifying hospitals are <b>uniform</b>	
5	and equitable.	
6	(b) Total disproportionate share payments to a hospital under this	
7	chapter shall not exceed the hospital specific limit provided under 42	
8	U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year	
9	shall be determined by the office taking into account data provided by	
10	each hospital that is considered reliable by the office based on a system	
11	of periodic audits, the use of trending factors, and an appropriate base	
12	year determined by the office. The office may require independent	
13	certification of data provided by a hospital to determine the hospital's	
14	hospital specific limit.	
15	(c) The office shall include a provision in each amendment to the	
16	state plan regarding Medicaid disproportionate share payments that the	
17	office submits to the federal Centers for Medicare and Medicaid	
18	Services that, as provided in 42 CFR 447.297(d)(3), allows the state to	
19	make additional disproportionate share expenditures after the end of	
20	each federal fiscal year that relate back to a prior federal fiscal year.	
21	However, the total disproportionate share payments to:	
22	(1) each individual hospital; and	
23	(2) all qualifying hospitals in the aggregate;	
24	may not exceed the limits provided by federal law and regulation.	
25	SECTION 6. IC 12-15-19-6, AS AMENDED BY P.L.218-2007,	
26	SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE	_
27	JULY 1, 2010]: Sec. 6. (a) The office is not required to make	,
28	disproportionate share payments under this chapter from the Medicaid	
29	indigent care trust fund established by IC 12-15-20-1 until the fund has	١
30	received sufficient deposits, including intergovernmental transfers of	
31	funds and certifications of expenditures, to permit the office to make	
32	the state's share of the required disproportionate share payments.	
33	(b) For state fiscal years beginning after June 30, 2006, if:	
34	(1) sufficient deposits have not been received; or	
35	(2) the statewide Medicaid disproportionate share allocation is	
36	insufficient to provide federal financial participation for the	
37	entirety of all eligible disproportionate share hospitals'	
38	hospital-specific limits;	
39	the office shall reduce disproportionate share payments made under	
40	IC 12-15-19-2.1 and Medicaid safety-net payments made in accordance	
41	with the Medicaid state plan to eligible institutions using an equitable	



methodology consistent with subsection (c).

2 reduced under this section shall, in accordance with the Medicaid state plan, be made:	e
a nlan ha mada:	
5 pian, of made.	
4 (1) to best utilize federal matching funds available for hospital	S
5 eligible for Medicaid disproportionate share payments unde	r
6 IC 12-15-19-2.1; and	
7 (2) by utilizing a methodology that allocates available funding	2
8 under this subdivision, and Medicaid supplemental payments a	S
9 defined in IC 12-15-15-1.5, in a manner that all hospitals eligible	e
for Medicaid disproportionate share payments unde	r
IC 12-15-19-2.1 receive payments using a methodology that	
(A) takes into account the situation of the eligible hospital	5
that have historically qualified for Medicaid disproportionate	<del>2</del>
share payments; and	
(B) ensures that payments for eligible hospitals are uniforn	1
and equitable.	
(d) The percentage reduction shall be sufficient to ensure that	t
payments do not exceed the statewide Medicaid disproportionate share	e
allocation or the amounts that can be financed with:	
(1) the amount transferred from the hospital care for the indigen	t
21 trust fund;	
(2) other intergovernmental transfers;	
23 (3) certifications of public expenditures; or	
(4) any other permissible sources of non-federal match.	_
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